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Is There an Increased Health Risk to Multi-generational Elderly Poor Not Found in
First-Generation Elderly Poor?

By

Donna E. Enfield, BSW

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of
Master of Social Work

Committee Members
Colin Hollidge, Ph.D., (Chair)
Madonna Waletzke, LICSW
Mary Kay Lannon, LISW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Is There an Increased Health Risk to Multi-generational Elderly Poor Not Found in First-
Generation Elderly Poor?

By Donna E. Enfield

Research Chair: Colin F. Hollidge, Ph.D.

Committee Members: Madonna Waletzke, LICSW; Mary Kay Lannon, LISW

This study sought to discover whether or not there is an increased health risk to multi-generational elderly poor not found in first-generation elderly poor. The research design called for a convenience sampling of 100 adults attending community center programs within one of four geographic areas in two Midwestern metropolitan counties identified by the U.S. Census Bureau as being low income. All surveys were to be anonymous, printed in English and completed independently by the survey participants. Survey questions included topics such as belief in parental poverty, perceptions of current poverty status, health issues and barriers to obtaining health care. Older adults living in low-income areas were surveyed in an attempt to uncover a correlation between parental poverty and current affects to health. Survey data collection proved to be more difficult than anticipated due to the lack of community programming for older adults and the time available for data collection. Only twenty surveys were collected and from a single collection site. Study results were statistically insignificant but still provide results which some professionals may find interesting. Survey participant ages ranged between 54 and 91 with a mean age of 71.5. Participants were found to have a mean of 6.86 daily medications. One participant reported being admitted to a hospital or visiting a hospital emergency room nine or more times within the past year. Social workers, health care professionals, community program developers and policy researchers will be interested in the findings of this study for the implications of long-term poverty upon the health of current populations. The quality of life would obviously be significantly impacted by chronic health conditions reported in this study. The financial burden to individuals, supportive programs and greater society could also be affected. Programs designed to break the cycle of poverty and thus prevent the perpetuation of poverty and its impacts to health could make a significant contribution to the quality of life of older adults.

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Introduction

Social Security is widely held to be an incredibly successful program for the eradication of poverty for the senior citizens of this country. Poverty rates among those age 65 and over dropped nearly 26% between 1960 and 2006 (Mayer, 2010). While this figure appears, on the surface, to demonstrate a stunning success, it fails upon further examination. The unrealistically low threshold for poverty is inadequate to address the needs of America's elderly (Wu, 2011). Social Security's sister program, Medicare, was supposed to address the growing medical needs for this population. We still, however, continue to see a correlation between poverty and unmet medical needs in the geriatric population (Beverly, Chernoff, Davis & Jones, 2007). According to the United States Census Bureau's 2009 report, nearly the entire United States indicated impoverished populations above ten percent and five states with poverty rates of 17% or greater (U.S. Census Bureau, 2010). A 2011 survey by the United States Department of Commerce indicated a poverty rate of 9% for populations aged 65 and older (United States Department of Commerce, 2011). Research shows that the food stamp program, designed to eliminate hunger among the poor, is not utilized by more than two-thirds of eligible older adults (Fuller-Thompson & Redmond, 2008).

The poverty threshold was developed by Mollie Orshansky in 1964 for the Social Security Administration (Richardson & Barusch, 2006) and has been revised infrequently since that time (U.S. Census Bureau, 2010). It was calculated by determining the cost of a thrifty food budget, only intended for short-term, emergency use, multiplied by three (Richardson & Barusch, 2006). The National Academy of Sciences, seeking to re-define poverty in more current and realistic terms, identified several areas of concern. The existing poverty calculations which

projected a poverty level of about one-half the median income in 1963-64, failed to reflect adjustments in increased cost of living standards, job-related costs, differences in medical costs, costs related to changing family structures or regional cost differences (U.S. Department of Commerce, 2011). Under the new definition, the poverty rate raised from 15.3% to 16% from all population groups and from 15.5% to 15.9% among those aged 65 and older. The report does not include figures for those living in near-poverty or list the duration of poverty. Though the poverty threshold is adjusted periodically due to inflation, the methods used by the federal government to calculate poverty, which would more accurately reflect actual living standards, has been updated infrequently since its creation in 1969.

The impact of poverty is much larger than a struggle to keep the bills paid. It includes multiple areas of an individual's life such as medical health (Mayer, 2010). Among the older adult population, 80% have one or more chronic health problems (Centers for Disease Control, 2006). According to McDonough and Berglund (2003), decreased economic status can be correlated with a decrease in health. Individuals who report long periods of poverty generally also reported a decreased level of health (McDonough & Berglund, 2003).

Poverty, according to Charles Tilly (1998) becomes so ingrained in individuals as to become cultural. Poverty, he states, is then passed from one generation to the next. Dannefor (2009) agrees, stating that public policies which maintain inequalities create durable economic groups. These groups, according to Dannefor, have fewer opportunities to elevate themselves above the social position of their parents. Groups afflicted by poverty are vulnerable and senior populations even more so than younger population groups (Judd & Moore, 2011).

Long-term poverty has continued, despite the success of social support programs such as Temporary Assistance to Needy Families (TANF) and Social Security. Tilly states that the very way in which society is organized creates firm exclusions of opportunities for segments of the population which make it nearly impossible for these population groups to break free of their poverty or near poverty (Tilly, 1998). Wood, Moore and Rangarajan's (2008) study indicated an increased risk of long-term poverty caused by such factors as parenthood, low educational achievements and health issues.

A thorough review of the current research literature failed to uncover any studies regarding possible increased medical risks to older adults presented by multi-generational poverty. Available research looks at the three topics separately and will be reviewed separately.

This paper will explore whether or not multi-generational poverty creates a greater medical impact on older adults than does first generation poverty. Given that no research was discovered addressing this specific question, the literature review will focus on three areas: long-term poverty, poverty in older adults and health issues among older adults.

Literature Review

Current research reveals several factors which contribute to the development and maintenance of poverty for protracted lengths of time. Poverty can either extend into or develop in later adulthood, which can become especially burdensome for adults who may, due to age or infirmity, no longer have the option of engaging in paid employment. Choi and McDougall (2009) state that age typically brings with it increased medical needs, which poverty stricken older adults may not be able to afford. The lack of access to basic necessities due to poverty may create increased risks to health not found in more affluent populations (McDonough & Berglund, 2003).

Long-term Poverty

Ludwig and Mayer (2006) examined research regarding the effects of marriage, the practice of religion and employment on the alleviation of the transmission of poverty to multiple generations. The authors contend that, while these bare laudable moral activities worthy of promotion, there remains a lack of strong empirical evidence connecting these particular activities to the transmission of poverty. Furthermore, a causal relationship could not be established. Poverty rates, they state, fluctuate as individuals move both into and out of poverty. Poverty may continue for long periods, but may or may not become multi-generational. The authors speculate that parents who choose to marry, engage in religious practices and have maternal employment may be fundamentally different than those who do not, eliminating any possibility of a causal relationship. The authors examined existing research on neighborhoods, the structure of children's families, religious adherence and maternal employment. The authors

explained how the complexity of these questions makes research very difficult. For example, if marriage is defined solely by the legal status and restricted to the biological parents of the child or children, it ignores the possibility of other definitions of family which may include step-parents and cohabitating parents. Religiosity is a difficult concept to define. Measuring it in terms of religious service participation may omit strong personal beliefs without the opportunity to participate in formal services, for example. These additional factors may skew the research, resulting in an inaccurate picture of the influences of parental values on long-term poverty. Ludwig and Mayer did find, however, that children earn higher wages as adults, on average, when raised in a home with their married biological parents.

Wood, Moore and Rangarajan (2008) agreed with Ludwig and Mayer (2006) that individuals frequently moved back and forth into and out of poverty. The authors monitored a 2,000 member group of predominantly female welfare recipients from New Jersey over a five year period. The study group was divided into two subgroups, consisting of those who had already been in the New Jersey state Temporary Assistance for Needy Families (TANF) program and those who were new to the same program. The researchers interviewed the study participants five times between 1999 and 2003 with 80% of the participants completing all five interviews and 95% completing at least one survey.

The surveys were used by the researchers to collect information on TANF history, place of residence, work experiences, educational achievement, number of children, English language skills, ethnicity, marital status, and income. The survey results revealed that about half of the survey participants exited the TANF program within the first year of entering, but the remaining half left the TANF program at a much slower rate. Differences in the exit rates were found by

the researchers to correlate with being well prepared to work, educational achievement, having employment experience, no children and good health. Individuals, however, with health issues, lower-aged children and less education were more likely to struggle to maintain employment. Their findings agree with a study by Wood, Rangarajan and Deke (2003), which revealed that the most rapid financial improvement was by those who had achieved at least a high school education, had employment experience, were young, in good health and had no young children. Wood, Moore and Rangarajan (2008) found that individuals in the study group who became a parent were 15% more likely to remain in poverty than those who remained childless. Only slightly more than 50% of the study participants were able to elevate their incomes above the poverty threshold during the course of the study. Given the very slim progress above the poverty threshold, Wood, Moore and Rangarajan noted the extreme vulnerability of these individuals to re-entering poverty. Groups with factors more likely to impact employment in addition to parent responsibilities were also at increased risk of remaining in or returning to poverty. The authors concluded that critical supports are needed to prevent this vulnerable population from returning to and remaining in long-term poverty. While TANF is a step in the right direction, Wood, Moore and Rangarajan point out the need for additional supportive programs.

Hartmann and English (2009) note that women experience differences in economic status related to their gender. The 2009 Census Bureau report confirms this, revealing that 17% of women are below the poverty threshold as contrasted with a rate of 12.2% for men (United States Census Bureau, 2009). Hartmann and English (2009) state that, while some women are better educated than in previous generations, many, especially immigrants, are not. Women are more likely to be divorced or never married, have fewer children, enjoy a greater degree of

health in their earlier years and live longer than previous generations. According to Hartmann and English, women generally have less income for retirement years, suffer increased health problems in later years and live longer than do men, which means that women have an increased risk of poverty as they age

Poverty among Older Adults

The population over the age of 65 is remarkably vulnerable to poverty (Mayer, 2010). Since the poverty threshold is calculated based upon caloric needs and those over the age of 65 are deemed to need fewer calories than younger adults, the poverty rate is calculated accordingly at eight to ten percent lower (Richardson & Barusch, 2006).

Due to the success of the Social Security program, a myth exists that seniors are exempt from poverty. The United States Census Bureau's 2009 report reflects a significant portion of the population still living in poverty (U. S. Census Bureau, 2009). The data shows that 10.3% of all adults aged 65 and over live below the poverty line. The rate jumps to an astonishing 15.6% among adults over the age of 65 living alone. The data is separated out by both age and gender which is further revealing. Among males living alone and aged 65 and older, the poverty rate is very high at 12.2% but for women living alone and aged 65 and older the rate climbs even higher to 17%.

Among the majority of both men and women, social security remains the major source of income for older adults (Finkle, Hartmann & Lee, 2007). An individual's financial vulnerability is based primarily upon the source of their income (Richardson & Barusch, 2006). Some older adults may find themselves in the position of being asset rich and cash poor, i.e., they have paid off their home and a car or two, but have very little cash (Bliss, 2011). The source of their

income may be vulnerable to economic change, such as those who lost pensions due to mergers, bankruptcies and other calamities (Richardson and Barusch, 2006). Investments vulnerable to decreasing interest rates translate into decreasing interest or dividend payouts to owners. Social security has been a safety net for seniors since the Act passed in 1935 following the stock market crash of 1929. Yet a report from AARP Foundation (Squires, 2011) states that multiple factors contribute to poverty in old age. Arnason (1998b) supports this, citing examples such as the collapse of pension incomes, death of a spouse who had income, minority status, and lack of eligibility for income supports. Mayer (2010) listed three basic causes of senior poverty: (1) poverty prior to retirement which might reflect the effects of poor health or create severe impacts to income during retirement, (2) retirement income may have been affected by events beyond the control of the individual, such as a divorce or spousal death and (3) increased medical expenses that drive even well-prepared seniors into poverty. Younger individuals who are in good health have the option of seeking out employment to supplement their income, but many seniors do not have that option. Hartmann and English (2009) discovered that a significant number of women nearing retirement actually worked more, presumably to increase retirement income. Finkle, Hartmann and Lee (2007) found that 13% of women and 22% of men aged 65 and over were still employed.

Poverty is particularly common among the female population, according to Choudhury and Leonesio (1997), affecting elderly women twice as often as elderly men and elderly minority women even more frequently. Finkle, Hartmann and Lee (2007) agree, reporting that elderly women receive Supplemental Security Income benefits at nearly double the rate of men. Elderly

women who have pension plans receive about half the amount of men, on average. Elder poverty may just be a continuum of a life spent in poverty.

Low income for adults of any age triggers eligibility for the food support program commonly called “food stamps”. With the food stamp program available, one would think that senior hunger would not be an issue, yet it remains a disturbing reality (Fuller-Thompson & Redmond, 2008). Haider, Jacknowitz and Schoeni (2003) and Wilde and Dagata (2002) report that only one-third of the elderly who are eligible for the food stamp program actually take advantage of this support. The health risks associated with poor nutritional status can prove disastrous and even fatal according to Fuller-Thompson and Redmond (2008). Their study revealed that even though utilization rates were abysmal, more women than men were taking advantage of food stamp benefits, as well as more African American and Hispanic individuals. The young-old were also more likely than the old-old to use food stamps. A troubling finding in the study was that the very poorest of the elderly poor were less likely to use food stamps than those individuals who were much closer to the upper margin of the poverty threshold.

Health Issues among Older Adults

Briesacher, Ross-Degnan, Adams, Wagner, Gurwitz and Soumerai (2009) conducted a study regarding the affordability of medications to low-income adults, which could certainly impact health. The researchers found that a far greater portion of disposable income was spent on medical expenses by individuals living in poverty than those not identified as poor.

Predictably, poorer health resulted in more dollars spent on health care expenses. In households with little income, the resulting impact on low-income households is far greater than their more affluent cohort.

McDonough and Berglund (2003) conducted a study wherein the participants were asked to self-rate their health. This study is particularly notable because it assesses individual's self-rated health over a period of about ten years and begins with a sample size of 5,000 individuals taken from the Panel Study of Income Dynamics. McDonough and Berglund noted the same patterns of exiting and re-entering poverty that was seen in the study by Wood, Moore and Rangarajan (2008). McDonough and Berglund (2003) discuss the importance of early life influences, such as experience living in poverty, loss of power over choices, limited opportunities, and demographic factors. These factors, taken together, may become a cultural component influencing the perpetuation of poverty, according to the study. McDonough and Berglund (2003) sought to examine whether or not the lack of parity in the distribution of material wealth and health care services could impact the health reported by individuals later in life. They examined the status of health as self-rated by the participants and correlated it to economic status, and length of time spent in poverty. The researchers concluded that the effects of previous poverty upon an individual's self-rated health are not ameliorated by increased economic status in later years. The researchers recognized the multiple limitations of the study, including the inability to assess factors such as nutritional deficits, housing issues and other topics common among populations struggling with poverty.

Hu (2007) conducted a study among low-income older African Americans in three housing residences in the southeastern United States, looking to assess health-related quality of life. Hu's results revealed that 79% of the study participants reported having two or more significant, chronic health conditions and 53% reported their health to be "fair" or "poor".

Briesacher, et al. (2009) conducted a study regarding the affordability of medications to low-income adults, which would certainly impact health. The reality of poverty, they found, meant that some individuals chose to pay for medical costs by sacrificing other essential purchases. Briesacher, et al. (2009) states that the burden of medical costs is disproportionately heavy for the population which lives below the poverty threshold. Research by Choi, Kim and Asseff (2009) examining reports of abuse involving older adults seems to agree, stating that lack of income creates the inability to pay for medical care and other basic necessities. Choi, Kim and Asseff found that of the cases investigated, 91.5% were associated with health issues involving neglect and/or self-neglect due to poverty restrictions. These findings remained valid even when Medicare and Medicaid were paying for services since many needed medical expenses were simply not covered by the programs. The researchers found that individuals would go without vital medications because there was no other alternative. Others had utilities disconnected when they chose to purchase medical supplies with utility bill monies. Children of these fragile elderly adults are sometimes living in poverty themselves and unable to render aid to their parents.

Research leaves little doubt that poverty impacts the health of older adults. Long term poverty has conclusively shown an impact to health in later life. The question remains, however, whether or not multi-generational poverty impacts the health of older adults to a significantly greater degree than does more recent poverty.

Conceptual Framework

Systems theory (Kirst-Ashman, 2008) promotes the idea that individuals work within a complex system that includes roles, boundaries, subsystems, relationships, input and output. When individuals, therefore, become trapped into a system that holds them in poverty, it can become difficult, if not impossible, to escape. The system itself, therefore, is the problem and not the individual. Systems theory tells us that poverty is frequently self-perpetuating. Low income, for example, may lead to poor nutrition, leading to poor health and poor school or work performance. These in turn lead to poor educational achievement or lack of job retention. Inadequate housing caused by poverty only adds to the problem. All of these influencing factors combine to retain the individual in poverty. Breaking this cycle of what Tilly (Tilly, 1998) terms “durable inequality” would be a laudable goal of policy advocates and social program development. The focus of policy improvement on structures built into the social systems which impede individual ability to elevate oneself to a better condition could potentially improve life for millions of individuals. The American work ethic places the blame upon the individual, but this is strongly contradicted by Tilly. McNamara’s (2007) research correlates with Tilly in finding that the effects of poverty in midlife contribute to late life poverty. The need to interrupt this cycle of poverty was underscored by the findings of McDonough and Berglund (2003) finding that past experiences with poverty continued to affect current health. Hu’s (2007) study points to a correlation between health conditions, poverty and a lower rating in life satisfaction among older, low-income adults. Mental health workers and medical social workers in older adult programs may wish to examine this topic further. The ability to pay for medications to

treat health conditions has obvious implications for social work practice. Briesacher et al. (2009) found that poor older adults faced with co-payments or the need to purchase medications not covered by insurance experienced greater impact to their meager budgets than did their more affluent peers. This means, they found, that health consumers sometimes must choose between necessary purchases. If social supports could be employed or improved to assist with basic needs in multiple areas such as housing and nutrition, the burden of health care costs could be reduced. Choi, Kim and Asseff (2009) examined the issue of elder neglect. Elder self-neglect, the authors found, frequently occurred due to the necessity of choosing between purchasing medical care and other necessities. They found that that older adult's health is frequently impacted by financial stress. In addition, the authors point out the correlation between parental poverty and poverty occurring in their adult children.

With multiple programs already employed to ameliorate the problems of poverty, social workers have to question where failure is occurring. Tilly's (1998) concept of durability of inequalities in the social systems must be a part of that discussion. The efficacy of the TANF program in New Jersey, examined by Wood, Rangarajan and Deke (2003) found that TANF users frequently moved back and forth into and out of poverty. They found that multiple factors influenced the success of the study participants and that the study participants frequently teetered precariously on the brink of poverty, unable to achieve true financial stability. The narrow margin many of these study participants had above the poverty line meant that a single incident could propel them back below the poverty line which supports the concept of the system of poverty. Study participants who were better equipped with more education and work experience, did not need child care and had better health were more likely to achieve financial stability.

Therefore, social programs could target those supportive services in order to better provide protection against the return to poverty.

The ability to work is tied closely to the ability to remain above the poverty line, but McNamara (2007) points out that much more is needed to help individuals out of poverty. McNamara found that poverty among women in the midlife years most often did not change in later years even if the women were employed. Differences in outcome, she found, could be influenced by benefits offered by the employer, such as pensions and medical care. Providing social programs which address these supportive programs may, therefore, be an important part of any social work programs designed to decrease poverty. The application of systems theory to the issue of poverty means that a system exists which promotes the retention of individuals into a durable and complex network.

Methodology

This study sought to answer the question, “Does multi-generational poverty provide increased health risks to older adults?” The data was gathered for a quantitative design study by means of a survey completed by the study participants.

Sample

Twenty participants in a senior assisted living facility participated in the research. The facility was located in an area identified by the census bureau as being the second lowest income area in the city. The 18 respondents who reported their age were between 54 and 91, with a mean age of 71.50 and a median age of 69.

Table 1. Frequency Distribution for Age

Age Range		Frequency	Percent
	50-59	3	17
	60-69	6	33
	70-79	5	28
	80-89	3	17
	90 & over	1	06
	Total	18	90
Missing	System	2	10
Total		20	100

16

All twenty participants reported their relationship status. Three stated that they have never married, four are married or in a committed relationship, six are divorced and seven are widowed.

Data Collection

Multiple community centers that were in contact with elderly poor people were contacted to inquire on the possibility of their site being used to collect data. A surprising finding was that not many senior community centers exist. Furthermore, few community centers have programs for seniors, the programs are poorly attended or participants commute to centers not located in their home communities. Some community center directors stated that their programs are largely attended by non-English speaking older adults. Multiple community staff suggested that research data could possibly be collected at assisted living facilities. The plan was that, once verbal permission was granted to collect data at a community center, this researcher would promptly send a letter to the director confirming the date and time of data collection along with a summary of the research project and a sample copy of the survey (Appendix A) to be administered and fliers (Appendix B) for the director to post an advertisement of the data collection project. This researcher would then call the day prior to the appointment to confirm the appointment. This procedure was followed, and one community center did agree to allow data collection, but when this researcher called the day prior to the appointed day, the staff cancelled the appointment, citing the belief that the data collection would violate Health

Insurance Privacy and Portability Act (HIPPA) regulations. Only one appointment could be obtained at a single site for data collection within the time allowed for this project.

The community director placed a letter describing the research survey in each resident's mailbox to advertise the research. The community room at the senior living facility was used to complete the surveys.

No specific identifying information such as name or address was requested. When the survey forms were completed, the study participants were asked to deposit the survey into a closed box with a slit opening to admit the form. The researcher did not handle the survey unless the survey participant requested assistance getting the form into the box. The box was kept under the supervision of the researcher at all times to insure the security and privacy of all completed surveys. Twenty surveys were collected over a three hour period.

Measurement

The survey (Appendix A) contained fifteen short questions. The survey participant indicated an answer by checking the appropriate blank. The survey included questions regarding demographics, first generation or multi-generational poverty, identification of possible health issues, data about medication usage and obstacles to obtaining medical care or prescriptions and where participants received assistance with their health care.

Protection of Human Subjects

The protection of the study participants was of paramount importance throughout this research project. Participants had the right to decline participation or to end participation at any time during the survey. The researcher understood that the older adult population may experience feelings of vulnerability and fear about answering any questions regarding financial

status. In order to fully respect and protect the study participants, no questions required any identifying information or any specific income amounts. Survey participants were provided with seating options which would allow privacy from other participants. Some participants, however, chose to be seated next to other participants and to socialize throughout the survey completion. This researcher did not observe any obvious distress on the part of any participants during the survey collection period. Completed surveys were deposited into a closed box by the survey participants and held under the direct supervision of the researcher during the survey process to protect the confidentiality of the survey participants while the survey process was ongoing. Completed surveys were held in a locked file storage box in a private office area within the private residence of the researcher. Once the research study was published, all surveys were shredded.

It was hoped that collecting data regarding current levels of poverty, possible multi-generational poverty and impacts to health through this original research study would provide some insight into possible relationships between poverty and health. Discovering whether or not multi-generational poverty created a greater impact to health than first generation poverty was the focus of this study.

Results

Findings

Table 2 demonstrates that 50% of the participants (N=18) indicated that they believed their parents were raised in poverty.

Table 2. Frequency Table of Belief in Parental Poverty

Belief in parental poverty		Frequency	Percent
	Positive belief in parental poverty	9	45
	Negative belief in parental poverty	4	20
	Parental poverty status unknown	5	25
	Total	18	90
Missing	System	2	10
Total		20	100

Health conditions data are reported in Table 3. Participants reported problems with: diabetes, lung disease, kidney disease, liver disease, high blood pressure, cancer, heart disease and other major health conditions. Table 3 shows the frequency distribution of health conditions. Fourteen participants (70%) reported at least one health condition. Eight of the participants (70%, N=14) reported both parental poverty and health conditions

Table 3. Current Health Conditions and a Positive Belief in Parents Raised in Poverty

			Number of Co-occurring Health Conditions						Total
			1	2	3	4	5	6 or more	
Parental Poverty	Positive belief in parental poverty	Count	2	2	1	1	1	1	8
	Negative belief in parental Poverty	Count	2	0	0	0	0	0	2
	Parental poverty status unknown	Count	1	3	0	0	0	0	4
Total		Count	5	5	1	1	1	1	14

Table 4 shows the participants' number of visits to the emergency room or hospital admissions during the past year.

Table 4. Belief in Parental Poverty and Frequency of Visits to the Hospital

		Number of Hospital Visits					Total
		None	0-1	2-4	5-8	9 or more	
Parental Poverty	Positive belief in parental poverty	2	1	4	0	1	8
	Negative belief in parental poverty	2	2	0	0	0	4
	Parental poverty status unknown	0	2	1	1	1	5
Total		4	5	5	1	2	1

$$\bar{x} = 9.563; p=.297$$

Table 5. Daily Medications Taken and Belief in Parental Poverty

	Parental Poverty	N	Mean	Std. Deviation	Std. Error Mean
Daily Medications	Positive belief in parental poverty	7	6.86	4.375	1.654
	Negative belief in parental poverty	4	5.50	6.455	3.227

Participants reported taking a range of 1 to 15 medications. Of those who reported an affirmative belief in parental poverty (N=7), the mean number of daily medications reported is 6.86. A t-test shows no significance at .433.

Discussion

This study may be the first to examine the influences of parental poverty upon the health of current study participants. This research examined multiple needs relevant to health care in an attempt to discover needs which may be unmet due to the effects of poverty. While the effects of long-term poverty upon study participants' health has been thoroughly researched, little research has been done to search for the effects of parental poverty upon a current generation. This research sought to discover whether or not a correlation might exist between health conditions and parents raised in poverty. The survey findings failed to uncover a statistically significant correlation between parental poverty and current affects to health. This does not, however, mean that the findings are clinically insignificant. Table 3 shows that half of the individuals reporting a belief in parental poverty had three or more co-occurring health conditions. This study is consistent with Hu's (2007) findings which revealed that 79% of the study participants reported two or more chronic health conditions. This study revealed that nine of the fourteen (64%) respondents for this question reported having two or more chronic health conditions and one reported an incredible burden of six chronic health conditions.

Table 4 demonstrates that six of the eight participants reporting parental poverty also reported visits to a hospital within the past year. Of those six participants, four had visited the hospital two to four times and one individual had visited nine or more times. Although this study did not demonstrate a significant relationship between the perception of parental poverty and the number of hospital visits, it is interesting to note that the number of participants reporting hospital visits overall was consistently higher for those who also reported belief in parental

poverty than for those that did not report parental poverty. This is consistent with the findings by McDonough and Berglund (2003).

This study relates to the findings of Briesacher, Ross-Degnan, Adams, Wagner, Gurwitz and Soumerai (2009). This study found that medication affordability could impact health. Our study found that three participants (17.6%) who responded to the question of medication compliance specifically stated that they could not afford their medications, providing a measure of support for the previous research findings.

McDonough and Berglund's (2003) research reported that the early effects of poverty to the health of individuals are not erased by a later increase in income. If the effects of poverty have long-term effects within a single generation, it may well hold true for these effects to continue onto the second generation of poverty. While this study cannot confirm this finding, it may provide a tantalizing hint toward this finding.

Future research may wish to re-examine the connection between parental poverty and current health conditions with clearer definitions of both poverty and parental relationships. Collecting a sample large enough to provide meaningful data would also improve research on this important topic. Extending research further into the connection between poverty and health by exploring the influences of multi-generational poverty could influence current and future policies and social work practices.

Limitations

Since the sample contained only twenty participants and was not randomized, it is not generalizable to a larger population. The United States Census Bureau clearly identified two areas of extreme poverty in each of two metropolitan counties in the targeted study area. Having

this data available was very helpful in accurately identifying populations of poverty and in locating areas which are in four discrete areas disbursed somewhat evenly throughout the targeted midwestern metropolitan area. Attempts by the researcher to locate community centers within these four identified geographical areas failed. Community center directors reported either that they did not have programs for older populations, the few participants who did come for senior programs lived outside of the area identified by the Census Bureau, the attendees had little ability to read or to speak English sufficient to complete a survey independently or the community directors failed to respond to this researcher's repeated inquiries. The program directors who did respond were generally extremely helpful in suggesting that this researcher attempt to collect data at senior housing facilities which have community centers located within their campuses. Only one appointment to collect survey data could actually be completed. A second appointment failed to result in data collection. This researcher mailed out survey advertisements for the director to post in advance and a copy of the survey to be administered. The day prior to the scheduled data collection, this researcher telephoned the director to confirm the appointment. The director cancelled the data collection in the belief that the survey questions would violate Health Insurance Privacy and Portability Act (HIPPA) requirements. Thus, this researcher was only able to collect data from one of the four identified geographical areas within the limited time frame for this research project. The research goal was to collect 100 surveys and only 20 were collected, representing only 20% of the anticipated data available for analysis. This researcher believes that, with more time been allotted to the project, additional sites could have been located and an adequate number of surveys collected to allow for a study with research significance. Additionally, the midwest metropolitan area targeted for the survey

contains large immigrant populations. Having surveys available in alternate languages may have increased survey site participation.

The survey asked the participants to report on the belief that their parents were raised in poverty. The term “parents” was not defined. As Ludwig and Mayer (2006) reported in their study, this identification may have different meaning for different individuals, thus causing some confusion and variability for the respondents in how to answer the question. The individuals raising the respondents may be other relatives or even unrelated individuals serving in the parenting role, for example, and may be included or excluded by the respondents when considering an answer.

Implications for Social Work Practice

These research findings may hold some implications for social work practice. Even though these research findings were not statistically insignificant, social workers and health care professionals may argue that it does provide information of clinical significance. Certainly it provides an impact to the quality of life for the individual respondents. Additionally, given the extremely high cost of medical care, reducing the number of hospitalizations and emergency room visits is probably a high priority for health care providers and insurance companies. Few people would deny that nine or more visits within a single year are an extremely high number. Public policy could be influenced by this evidence that long term poverty does possibly hold implications for the health of future generations. Even if the survey results are statistically insignificant, this data may indicate a clinical significance worthy of further examination.

Poverty in America is a significant problem. Our vulnerable elderly population becomes increasingly vulnerable when affected by the stresses of poverty. Breaking the cycle of poverty,

which sometimes stretches through multiple generations, to reduce the health risks which correlate with poverty should translate into a more positive aging experience for our precious older generation.

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Survey Instructions: I appreciate your decision to participate in this research project. You have been chosen to participate because you participate in activities at a senior community center. This survey is completely confidential and all surveys will be destroyed after the research project is completed. Your participation is completely voluntary. If any question feels difficult, please feel free to skip it. By completing this survey you are consenting to participate in this survey. You will not be given any thing of value to complete this survey. Your participation or lack of participation will not affect your relationship with the community center in any way. Thank you for helping with this research.

1. Please state your age _____.
2. Please indicate your marital status.
____never married ____married/committed relationship ____ divorced ____widow/widower
3. In your opinion, what annual income amount represents the poverty line?
____ Under \$10,000 ____Under \$15,000 ____Under \$20,000 ____ Under \$25,000
4. Do you believe that you grew up in poverty?
____yes ____maybe ____no ____no opinion
5. Do you believe that you are living in poverty now?
____yes ____maybe ____no ____no opinion
6. Were your parents raised in poverty? ____yes ____no ____don't know
7. Please indicate any of the following health conditions which you have or have ever had.

____ Diabetes	____High blood pressure
____Lung disease	____Cancer
____Kidney disease	____Heart disease
____Liver disease	____Other major health problem

8. Do you have annual check-ups? _____yes _____no

Please indicate the number of doctor visits you usually have per year.

_____ 0 _____ 1-5 _____ 6-10 _____ 11-20 _____ 21 or more

9. Please indicate the number of times you have been hospitalized or seen in the emergency room in the past year.

_____ none _____ 0-1 _____ 2-4 _____ 5-8 _____ 9 or more

10. Have you ever cancelled or missed any medical appointments?

_____ yes _____ no

11. Please indicate issues which make it difficult to attend appointments even if you do not actually miss your appointments.

_____Transportation issues _____ Financial issues _____ Forgot

_____Too sick _____ Family issues prevented

_____Cannot miss work _____No time to go _____ Some other reason

12. How many medications do you take daily? _____

13. Are there medications you do not take or miss taking? _____yes _____ no

14. Reason for not taking medications: _____Not applicable _____Cannot afford _____
Unable to pick up medications _____ Side affects _____ Did not understand the
instructions _____ You felt you didn't need the medications _____Other reason

15. Please indicate anyone who helps you with your health care needs.

_____ No help needed _____ No help available _____Child _____Spouse _____Sibling

_____ Friend _____ Clinic Social Worker _____ Case Manager _____ Other

SURVEY

St. Catherine University/St. Thomas University
School of Social Work

(Date)

(Time)

- Completely anonymous
- Has no affect on your participation at the community center
- All surveys will be destroyed after the project is completed
- Will provide information for social workers working with senior adults
- Collects data about poverty, health and barriers to attaining health services
- Takes no more than 10 minutes to complete